U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 15 October 2004

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In the Matter of:

DENNIE FLEMING,
Claimant
v.

BRANHAM & BAKER COAL COMPANY,
Employer
and
DIRECTOR, OWCP
Party-in-Interest

Case No. 2003 BLA 05543

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James D. Holliday, Esq.
For the Claimant
Erik A. Schramm, Esq.
For the Employer
Before: STUART A. LEVIN
Administrative Law Judge

DECISION AND ORDER -- DENYING BENEFITS

This proceeding arises from a claim for benefits under 30 U.S.C. §§ 901-945. In accordance with the Act and regulations issued thereunder, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs for a formal hearing.

Benefits under the Act are awardable to persons who are totally disabled within the meaning of the Act due to pneumoconiosis. Benefits are also awardable to the survivors of persons whose death was caused by pneumoconiosis, and for claims filed prior to January 1, 1982, to the survivors of persons who were totally disabled from pneumoconiosis at the time of the deaths. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment. It is commonly known as black lung.

Issues

The following issues are presented for resolution:

(1) Whether the Claimant has pneumoconiosis;

(2) Whether Claimant's pneumoconiosis, if present, arose out of coal mine employment;

(3) Whether the Claimant is totally disabled; and,

(4) Whether the Claimant's total disability is due to his pneumoconiosis.

Procedural History

Claimant applied for benefits under the Act on February 12, 2001 (DX 2). The District Director issued a finding on October 4, 2001 with a schedule for submission of additional evidence (DX 12). Following consideration of the additional evidence, the District Director issued a Proposed Decision and Order on March 18, 2002, denying the claim for benefits (DX 18). Claimant requested reconsideration on April 12, 2002 (DX 19) and on May 3, 2002, the District Director issued a Revised Proposed Decision and Order (DX 20, 21). In the revised determination, the District Director found that Claimant had established the presence of pneumoconiosis. that such pneumoconiosis arose out of coal mine employment and that he was totally disabled due to pneumoconiosis. Employer requested a hearing on June 3, 2002 and again on August 23, 2002 (DX 22, 24) and this matter was referred to this Office on March 3, 2003 (DX 28).

A hearing was held on July 10, 2003 in Buckhorn, Kentucky. Subsequent to the hearing, pursuant to agreement of the parties at the hearing, Employer submitted a report by Dr. B. Broudy dated August 26, 2003 reviewing the additional medical reports submitted by Claimant. Dr. Broudy's August 26, 2003 review report is hereby admitted into evidence as Employer's Exhibit 3.

Subsequent to the receipt of Dr. Broudy's August 26, 2003 report, Claimant requested an enlargement of time to submit a statement from Dr. Alam responding to Dr. Broudy's rebuttal evidence. By Order dated November 12, 2003, Claimant was allowed until January 12, 2004 to submit such evidence as provided under Section 725.414(a)(2)(ii). Claimant submitted the January 8, 2004 report of Dr. Alam on January 9, 2004. Dr. Alam's January 8, 2004 report is hereby entered into evidence as Claimant's Exhibit 4. Claimant and Employer have submitted briefs, and the record is now closed.

At the hearing, the parties agreed that Claimant had at least twenty-two (22) years of coal mine employment (Tr. 26). Claimant's Social Security Administration Earnings Statement establishes thirty-one (31) years of coal mine employment (DX 5). Therefore, I find Claimant has established thirty-one (31) years of coal mine employment.

Background

Claimant, Dennie Fleming, was born on August 11, 1941 and has a 9th grade education (DX 2, Tr 26). Mr. Fleming married Iolene Roberts on June 23, 1967 and she is his sole dependent for purposes of benefit augmentation (DX 7). Claimant testified he began working in coal mine employment at age 16 and his last coal mine employment was in 1997. He worked a variety of jobs including running equipment and loading coal. He last worked for ten years as a

supervisor. Claimant worked three years in underground coal mines and the rest of his employment was in strip mines above ground. Claimant continued to run equipment even as a supervisor until the last three years when his back problems prohibited him from those tasks (Tr. 27-28, 33-34). Claimant testified he smoked cigarettes for forty years and he quite smoking about five years ago (Tr 31).

Entitlement to Benefits

To be entitled to benefits under Part 718, Claimant must establish by a preponderance of the evidence that (1) he suffers from pneumoconiosis; (2) the pneumoconiosis arose out of coal mine employment; (3) he is totally disabled; and (4) his total disability is caused by pneumoconiosis. See Gee v. W.G. Moore & Sons, 9 BLR 1-4 (1986). Failure to establish any of these elements precludes recovery under the Act.

Establishing Pneumoconiosis

There are four means of establishing the existence of pneumoconiosis, set forth at §718.202(a)(1) through (4): x-ray evidence; biopsy evidence; regulatory presumptions; and physicians opinion based upon objective medical evidence.

X-ray Evidence

Pursuant to § 718.202(a)(1), the existence of pneumoconiosis can be established by chest x-rays conducted and classified in accordance with §718.202. The record includes the following x-ray reports:

EX. No.	Physician Qualifications	Date	Reading
DX 8	M. Wicker	02-28-01	No pneumoconiosis, chronic obstructive pulmonary disease, changes at bases consistent with bronchitis, fullness in both hila.
DX 8	E. Sargent, B/BCR	02-28-01	Quality 1, emphysema

			widened aorta, lung loss at bases
EX 1	B. Broudy, B	02-28-01	0/0, emphysema
EX 1	B. Broudy, B	11-15-02	No pneumoconiosis, emphysema, atelectasis, basilar fibrosis
EX 2	A. Dahhan, B	06-06-03	No evidence of pneumoconiosis, emphysema

BCR indicates a physician certified in radiology or diagnostic roentgenology by the American Board of Radiology Inc. or the American Osteopathic Association. 20 C.F.R. §727.206(b)(2)(III). B indicates a physician who was an approved "B-reader" at the time of the x-ray reading. A B-reader has demonstrated expertise in assessing and classifying x-ray evidence of pneumoconiosis, and has been approve d as a proficient reader by the National Institute for occupational Safety & Health, U.S. Public Health Service, pursuant to 42 C.F.R. §37.51 (1982).

The record also included narrative x-ray readings in Dr. Alam's treating notes, however, these x-ray readings did not meet the quality standards for x-ray readings set forth at 20 C.F.R. §718.102 and, thus, I have not considered them under this subsection of the regulations. Dr. Broudy and Dr. Dahhan read a series of x-ray films from February 17, 1998 through August 8, 2000 as part of their medical review reports. Since the original readings of these x-ray films are not included in the record and since these readings exceed the number allowed by the regulatory provisions, I find no basis for including these opinions in the record. See 20 C.F.R. §725.414(a)(3)(i).

On review of the x-ray evidence noted above, I note that none of the physicians found radiographic evidence of pneumoconiosis. In particular, I accord great weight to the negative readings by Drs. Broudy and Dahhan who are highly qualified as B-readers. I find the uncontradicted negative readings of record clearly indicate Claimant has not established the presence of pneumoconiosis by x-ray under the provisions of Section 718.202(a)(1).

The second method for establishing pneumoconiosis is by biopsy evidence under the provisions of Section 718.202(a)(2). There was no such evidence submitted in this matter, thus, pneumoconiosis is not established under §718.202(a)(2). None of the referenced presumptions are applicable and, thus, pneumoconiosis is not established under §718.202(a)(3).

The final method for establishing pneumoconiosis, notwithstanding negative x-ray reports, is by reasoned medical opinions under subsection 718.202(a)(4). This regulation provides that any such finding by a physician must be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examinations, and medical and work histories.

Dr. M. Wicker examined Claimant on February 28, 2001 and reported an increased AP diameter on inspection, normal findings on palpation, and clear findings on auscultation. Dr. Wicker reported no evidence of pneumoconiosis on chest x-ray and he also conducted pulmonary function study and blood gas study testing. Dr. Wicker diagnosed no evidence of pneumoconiosis. He stated Claimant does not retain the respiratory capacity to do his usual coal mine employment, and this limitation is due to his cigarette abuse (DX 8).

Claimant submitted treatment notes from Dr. J. Alam, a pulmonary specialist and also Claimant's treating physician. Dr. Alam's first note is dated January 12, 2000 when he evaluated Claimant. This report includes a handwritten note to "assess coal worker's pneumoconiosis". In a typed report, Dr. Alam diagnosed severe chronic obstructive pulmonary disease, sleep apnea, hypothyroidism, depression, and neck thyroid nodule on January 19, 2000. He reported reviewing a series of x-ray films and found no changes from December 30, 1997 to now (Jan, 2000), all films showed chronic granulomatous changes of chronic obstructive pulmonary disease. Dr. Alam continued to follow Claimant and advised him regarding his pulmonary condition regarding scheduled surgery for Zenker's diverticulum. In March, 2000, Dr. Alam reported the surgery presented no respiratory problems and he continued to prescribe inhalers. Notes from May, June, and July, 2000 continue to note the presence of chronic obstructive pulmonary disease with treatment by medication and bronchodilators. In August, 2000, Claimant had right lower lobe pneumonia and was hospitalized. Reports from December, 2000 and January and March, 2001 also indicate end stage COPD with depression and history of hypothyroidism. In June, 2001, Dr. Alam also noted Claimant's musculoskeletal pain and degenerative joint disease in addition to the COPD, hypothyroidism and depression.

In December, 2001, Dr. Alam treated Claimant for a tongue rash which was a side effect from medication Claimant was taking. At this time, the diagnosis list included coal worker's pneumoconiosis, 0/1 as well as the hypothyroidism, depression, COPD, Zenker diverticululm status-post surgery, and degenerative joint disease (arthritis). Dr. Alam noted severe obstruction on pulmonary function study testing.

On December 6, 2001 Dr. Alam stated the miner has chronic dust disease of the lungs caused by inhaling coal mine dust notwithstanding the negative chest x-ray reports. Dr. Alam stated the diagnosis of occupational lung disease due to coal mine employment is based on the presence of chronic bronchitis in spite of the fact the miner quit smoking more than one year earlier. Dr. Alam stated the pulmonary function study provide additional documentation of the presence of an occupational lung disease. Finally, he stated clinical and physical findings of rhonchi on auscultation and limited ability to exercise in combination with his history as a miner lead to this diagnosis. Dr. Alam recommended a cardiopulmonary exercise test (DX 15).

Additional records submitted at Claimant's Exhibit 1 include an undated list of diagnoses which includes the same diagnoses listed in December, 2001. In July, 2002, Dr. Alam performed a cardiopulmonary exercise test on Claimant and he reported it showed evidence of severe airflow obstruction. On a follow-up visits in 2002, Dr. Alam occasionally listed coal worker's pneumoconiosis as one of the diagnoses in his examination reports. Most consistently, however, he lists end stage COPD, and arthritis with back pain (CX 1). At a deposition taken on June 18, 2003, Dr. Alam stated Claimant's worst medical condition is his chronic obstructive pulmonary disease (COPD) which he stated is due to 24 to 25 years of coal mine employment and Claimant's past history of smoking cigarettes, although he quit one and a half years earlier. Dr. Alam stated Claimant's history is consistent with an occupational lung disease. He also stated it is difficult to separate out the effect of cigarette smoking and coal mine dust exposure. Dr. Alam stated further on chest x-ray Claimant has classical COPD and chronic interstitial changes that are compatible with coal worker's pneumoconiosis. Based on pulmonary testing, Dr. Alam stated Claimant does not have the respiratory capacity to do his prior coal mine employment. He noted Claimant is not on home oxygen at this point because he condition is not within the guidelines of Medicare. On cross-examination, Dr. Alam agreed there is no chest x-ray reading of pneumoconiosis from a board certified radiologist or B-reader, however, he stated he is relying on Claimant's thirty year history of coal mine employment when making his diagnosis of coal worker's pneumoconiosis. Dr. Alam also agreed he did not know Claimant's duties and whether or not he was exposed to coal mine dust or worked in an office while employed in coal mine employment (CX 3).

In the January 8, 2004 letter, Dr. Alam stated Claimant's thirty-seven years of coal mine employment exposed him to coal mine dust and he stated further Claimant's time spent in coal mine employment is the "Major denominator" in getting coal worker's pneumoconiosis. Although Dr. Alam noted some dispute on chest x-ray readings, he pointed out many chest x-ray readings agree changes are present, the disagreement is to whether the changes are caused by cigarette smoking or coal dust exposure. Dr. Alam stated, "I agree that Mr. Fleming has a smoking history but working in coal mines definitely contributed partly for his COPD and emphysema. Dr. Alam noted Dr. Broudy agreed pulmonary function study showed abnormalities. Dr. Alam also noted that since Claimant quit smoking two years ago and the pulmonary function study results and pulmonary symptoms continue to get worse, it is reasonable to say part of the lung disease is contributed from coal dust exposure which is a progressive disease and worsens with age. Dr. Alam again reiterated Claimant showed severe pulmonary limitation on the cardiopulmonary exercise test and because of his exposure to coal dust, chest x-ray findings and pulmonary function study results, he attributed the changes on the cardiopulmonary test to coal worker's pneumoconiosis. Dr. Alam concluded based on Claimant's work history, pulmonary function study changes and most recent positive chest x-ray, Claimant has pneumoconiosis. He stated part of Claimant's disease has been caused by coal dustexposure which is causing the chronic symptoms even though he has quit smoking (CX 4).

On November 14, 2002, Dr. B. Broudy, reviewed the medical evidence. He reported a series of chest x-ray films was negative for pneumoconiosis. He also reviewed additional medical evidence. Dr. Broudy concluded on review of the evidence that there was no evidence of coal worker's pneumoconiosis or chronic respiratory or pulmonary disease related to Claimant's coal mine employment based on the negative chest x-ray readings and the evidence of

moderate to severe chronic obstructive airway disease due to the miner's long history of cigarette smoking. Dr. Broudy stated Claimant is not able to do his coal mine employment both in consideration of his total medical condition and more particularly in consideration of his respiratory system. Dr. Broudy concluded, however, that Claimant does not have any totally disabling respiratory or pulmonary impairment arising from his former coal mine employment (EX 1). The next day, on November 15, 2002, Dr. Broudy examined Claimant and reported chest expansion slightly diminished, markedly diminished aeration, severe expiratory delay throughout with occasional slight wheezing, but otherwise few if any advential sounds. The spirometry showed severe obstructive airways disease with significant impairment after dilation. On blood gas studies, Claimant demonstrated mild resting arterial hypoxemia and on chest x-ray film, Dr. Broudy reported no evidence of coal worker's pneumoconiosis. Dr. Broudy diagnosed: 1) severe chronic obstructive airway disease with mild responsiveness to bronchodilator; 2) history of hiatal hernia with gastroesophageal reflux; and 3) history of depression. Dr. Broudy concluded there was no evidence of pneumoconiosis and no evidence of any chronic pulmonary disease related to coal mine employment. He also concluded Claimant had no disease resulting in impairment related to his coal mine employment. Dr. Broudy did conclude Claimant is unable to do his usual coal mine employment from a respiratory standpoint, however, he stated Claimant is not totally disabled due to dust exposure from his coal mine employment, due to pneumoconiosis or any other chronic respiratory or pulmonary disease due to coal mine employment (EX 1).

On August 26, 2003, Dr. Broudy reviewed additional x-ray reports and evidence. He stated the report of Dr. Baker (set forth below) did not include any discussion as to why Dr. Baker found the treating physicians conclusions more reasonable or more accurate than other medical opinions. Dr. Broudy then reviewed Dr. Alam's deposition testimony in some detail. He agreed with Dr. Alam's statement that underground miners have a higher incidence of coal worker's pneumoconiosis, however, this Claimant only worked 5 - 6 years in underground coal mine employment, so his risk based on many years of surface mining was lower than if he had worked underground the entire time. Dr. Broudy, however, disagreed with Dr. Alam's assertion that miner's are 50% more likely to get coal worker's pneumoconiosis than the general public, since the rate in the general public is zero. Dr. Broudy also found Dr. Alam's statement regarding emphysema and the improvement expected when the miner quit smoking to be incorrect. Dr. Broudy stated that pulmonary emphysema due to cigarette smoking is a chronic irreversible disease and would not improve even after smoking ceases. This is because emphysema destroys the lung units, specifically the alveoli and supporting structures including the vasculature. If Claimant had quit smoking early in his smoking history before the years it took for chronic obstructive airways disease to develop and destroy lung units, then he would have avoided serious emphysema.

Finally, Dr. Broudy disagreed with Dr. Alam's statement that the results of the cardiopulmonary exercise test were the basis for the diagnosis of coal worker's pneumoconiosis. Dr. Broudy stated this exercise test shows the miner's respiratory capacity and does not produce results which indicate the etiology of any changes demonstrated. Dr. Broudy also challenged Dr. Alam's diagnosis based on Claimant's history and symptoms since symptoms due to an industrial bronchitis subside after employment ceases. Dr. Broudy stated that chest x-ray changes and/or a lung biopsy with a history of coal mine employment are needed to diagnose coal worker's

pneumoconiosis and Dr. Alam had neither. Finally, Dr. Broudy stated that contrary to Dr. Alam's statements, it is possible to determine the difference between the effects of cigarette smoking and coal dust exposure. Dr. Broudy stated a severe disabling respiratory impairment due to pneumoconiosis usually manifests as a restrictive defect or at least a restrictive and obstructive mixed defect. One would expect far advanced pneumoconiosis or complicated pneumoconiosis to be seen on chest x-ray with a disabling respiratory impairment due to pneumoconiosis. In this case, the miner's long history of cigarette smoking combined with the typical obstructive defect of emphysema and the presence of emphysema on chest x-ray without the presence of pneumoconiosis on x-ray are all factors leading Dr. Broudy to the conclusion the miner's respiratory disability is due to emphysema due to his long history of cigarette smoking (EX 3).

On June 6, 2003, Dr. A. Dahhan, a pulmonary specialist, examined Claimant and reported an increased AP diameter with hyperresonance to percussion. Dr. Dahhan also reported auscultation revealed reduced air entry to both lungs with scattered expiratory wheezes. Dr. Dahhan performed several pulmonary tests and conducted a chest x-ray which he found was negative for pneumoconiosis. In addition, he reviewed the medical records, including a series of chest x-ray films which he found negative for pneumoconiosis. Dr. Dahhan concluded: 1) there are insufficient objective findings to justify a diagnosis of coal worker's pneumoconiosis based on the obstructive abnormalities on clinical examination of the chest, the obstructive abnormality on spirometric testing with significant response to bronchodilator therapy, negative chest x-ray readings and treatment by the Claimant's treating physician with bronchodilators; 2) Claimant has chronic obstructive pulmonary disease; 3) from a respiratory standpoint, Claimant does not retain the physiological capacity to do his previous coal mine employment because of the obstructive airway disease; 4) the obstructive airway disease is due to Claimant's history of cigarette smoking for more than 50 years; and 5) the obstructive airway disease is not caused by coal dust or pneumoconiosis since Claimant demonstrated a significant response to bronchodilators which is inconsistent with the permanent effects of coal worker's pneumoconiosis, since the treating physician has prescribed bronchodilators and since there is no complicated pneumoconiosis or progressive massive fibrosis present to cause the secondary obstructive abnormality (EX 2).

On August 13, 2003, Dr. G. Baker, a pulmonary specialist, reviewed Dr. Alam's medical records and the report of Dr. Wicker. Dr. Baker stated it is his opinion that coal dust played a significant part in Claimant's respiratory defect. He stated Claimant's 29 years of coal mine employment can not be excluded as a causative factor in the miner's respiratory impairment. Dr. Baker stated the miner's cigarette smoking is also a factor, however, in his opinion coal worker's pneumoconiosis is a significant contributing factor to the miner's pulmonary disability. Dr. Baker based this conclusion on the finding of chronic dust disease in Dr. Alam's notes and the fact that Dr. Wicker had no rationale for excluding 29 years of coal mine employment as a causative factor and he did not discuss the difference between legal and clinical pneumoconiosis. Dr. Baker stated he agreed with the assessment's of Dr. Alam, the miner's treating physician, since he has spent more time with the miner over the years. Dr. Baker concluded Claimant has a chronic dust disease of the lungs due to coal mine employment which has played a significant part in Claimant's totally disabling respiratory impairment and he reiterated that cigarette smoking is also a factor (CX 2).

On consideration of these medical reports, Dr. Alam's diagnosis of pneumoconiosis is based on the miner's employment history, clinical findings and the results of the cardiopulmonary exercise test. Dr. Alam's basis for his conclusion, however, was weakened when he stated at the deposition that he did not know the Claimant's job duties and whether or not he was exposed to coal mine dust in his employment. Dr. Alam does note in his most recent letter that with his experience working in a mining community, he is sure Claimant was exposed to coaldust during his coal mine employment He also noted a positive chest x-ray and the results of pulmonary function studies as supporting his finding that Claimant has coal worker's pneumoconiosis. The x-ray report, however, is not included in the record.

Dr. Broudy has stated that the results of the cardiopulmonary exercise test while establishing Claimant's pulmonary limitations does not address the etiology of the limitations demonstrated. Dr. Broudy and Dr. Dahhan concluded that pneumoconiosis is not present based on the negative chest x-ray findings, the clinical findings on physical examination, the results of laboratory testing, including pulmonary function study and blood gas study. These findings are well supported by Dr. Wicker's conclusions on examination as well. Dr. Baker reaches a contrary conclusion on consideration of the medical evidence, but his report includes mainly his opinion based on the treating physician's findings without discussing any laboratory test results or findings on examination which support his conclusion. The record indicates Dr. Alam, Dr. Broudy, Dr. Dahhan and Dr. Baker are all pulmonary specialists, thus, the qualifications of the physicians does not provide any basis for crediting the report of one physician over the other one. I find, however, that the conclusions set forth in the reports of Dr. Broudy, Dr. Wicker, and Dr. Dahhan are better supported than the conclusions set forth in the reports of Dr. Alam and Dr. Baker.

Dr. Dahhan discusses the basis for his conclusion the miner's pulmonary obstructive impairment is due to emphysema due to cigarette smoking and not to dust exposure and coal worker's pneumoconiosis. Dr. Dahhan notes the response Claimant demonstrated to bronchodilators on pulmonary function study which is not consistent with coal worker's pneumoconiosis. In addition, he notes Claimant's treating physician has prescribed multiple bronchodilators which is also not consistent with coal worker's pneumoconiosis.

In contrast, Dr. Alam relies on his examination findings, Claimant's work history and the results of the cardiopulmonary test, although Dr. Alam did admit his initial diagnosis was made prior to the cardiopulmonary test. Dr. Alam's reliance upon the cardiopulmonary test, however, is less credible since that test measures the pulmonary capacity but does not indicate the etiology of any pulmonary disability. Dr. Alam's deposition testimony demonstrated the tenuous basis for his diagnosis of pneumoconiosis. He admitted he had not reviewed any chest x-ray reports, he had not conducted the cardiopulmonary exercise test prior to his diagnosis and he did not know what Claimant's job duties were or what his dust exposure was. The additional letter now indicates Dr. Alam is relying upon a positive chest x-ray report, but that report is not in the record. Furthermore, Dr. Alam discussed generally Claimant's exposure to coal dust and, thus, Dr. Alam's conclusion that a least part of Claimant's pulmonary condition is due to coal dust exposure, however, he did not address the questions raised about his treatment with bronchodilators which are not consistent for coal worker's pneumoconiosis nor improvement on pulmonary function study with the use of bronchodilators which Dr. Dahhan states is not

consistent with coal worker's pneumoconiosis. Dr. Baker's reliance upon Dr. Alam's opinion as the treating physician is similarly flawed. In contrast, Dr. Dahhan's better reasoned and better supported conclusions are supported by the report of Dr. Broudy as well as the report of Dr. Wicker.

As Dr. Alam is Claimant's treating physician, I must consider his opinion pursuant to Section 718.104(d). This new regulation in effect states that a treating physician's opinion shall be accepted "in the absence of contrary probative evidence" and may be given controlling weight if it is credible "in light of its reasoning and documentation, other relevant evidence and the record as a whole." Section 718.204(d)(5). For reasons set above, however, I find Dr. Alam's opinion is outweighed by the contrary probative evidence. Dr. Alam's reports did not include the thorough discussion of the medical evidence included in the reports of Drs. Broudy and Dahhan. Furthermore, his deposition testimony illustrated the flaws in his reasoning and lack of support for his diagnosis of pneumoconiosis by any medical tests, other than the results of the cardiopulmonary exercise test which is limited in the diagnosis of pneumoconiosis as noted above. His recent letter includes mainly general comments on exposure to coal dust without identifying specific findings on pulmonary testing which supports his conclusion that coal dust is responsible for a t least part of Claimant's pulmonary changes. While he does state the fact Claimant quit smoking two years ago is the basis for his finding that coal worker's pneumoconiosis is causing chronic symptoms, he does not discuss the particular changes on pulmonary testing noted by Dr. Dahhan. Dr. Dahhan's conclusions, thus, are supported by specific objective findings on pulmonary testing while Dr. Alam's conclusions are supported by a more general discussion of exposure and probably results. Thus, I find Dr. Alam's diagnosis of pneumoconiosis not as well supported nor as well reasoned and it is outweighed by the other probative medical reports of record, specifically the reports of Dr. Dahhan, Dr. Broudy, and Dr. Wicker. Accordingly, I find Claimant has not established pneumoconiosis under the provisions of subsection 718.202(a)(4).

On consideration of all of the evidence of record, therefore, I find Claimant has not established pneumoconiosis under Sections 718.202(a)(1) through (a)(4).

Total Disability

The determination of the existence of a totally disabling respiratory or pulmonary impairment shall be made under the provisions of Section 718.204. A claimant shall be considered totally disabled if the irrebuttable presumption of Section 718.304 applies to his claim. If the irrebuttable presumption does not apply, a miner shall be considered totally disabled if he is prevented from performing his usual coal mine work or comparable and gainful work. In the absence of contrary probative evidence, evidence which meets one of the Section 718.204(b)(2) standards shall establish the claimant's total disability. According to Section 718.204(b)(2), the criteria to be applied in determining total disability include: 1) pulmonary function studies, 2) arterial blood gas tests, 3) a cor pulmonale diagnosis and 4) a reasoned medical opinion concluding total disability.

There is no disagreement among the physicians that Claimant is totally disabled by his obstructive pulmonary disease and they support these conclusions with the results on pulmonary

testing, including pulmonary function study results, blood gas study results and the results of a cardiopulmonary exercise test. Thus total disability is established under subsections 718.204(b). There is disagreement, however, as to the cause of the disability. For reasons similar to those set forth above, I find the reports of Drs. Dahhan, Broudy and Wicker outweigh the reports of Drs. Alam and Baker. The reports of Drs. Dahhan, Broudy and Wicker all conclude that Claimant's obstructive pulmonary disease is due to his long history of cigarette smoking. Thus, these physicians concluded Claimant is not disabled by pneumoconiosis or any pulmonary condition related to coal mine dust exposure during his years of coal mine employment. I find the discussion and conclusions regarding the etiology of Claimant's disabling pulmonary impairment by Dr. Dahhan, Dr. Broudy and Dr. Wicker better reasoned and better supported and, thus, I find these conclusions outweigh Dr. Alam's and Dr. Baker's contrary findings. Accordingly, I find Claimant has not established total disability due to pneumoconiosis as required by subsection 718.204(c). Therefore, Claimant has not established total disability due to pneumoconiosis under the provisions of Section 718.204.

Since Claimant has not established either the presence of pneumoconiosis or total disability due to pneumoconiosis, his claim for benefits shall be denied.

ORDER

The claim of Dennie Fleming for benefits under the Act shall be DENIED.

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STUART A. LEVIN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20018-7601. A copy of this notice must also be served on Donald S. Shire, Associate Solicitor, Room N-2605, 200 Constitution Avenue, N.W., Washington, D.C.